MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

SECLUSION AND RESTRAINT REVIEW COMMITTEE

Effective Date: November 17, 2004 **Policy #: QI-04**

I. PURPOSE

A. To provide a post-incident review process for all restraint and seclusion interventions separate from the review conducted by patient treatment teams, and to obtain interdisciplinary advice and guidance on the use of these interventions at Montana State Hospital

II. POLICY:

A. Montana State Hospital (MSH) will have an organized, interdisciplinary Seclusion and Restraint Committee to review and monitor seclusion and restraint usage, provide an educational resource for hospital staff, and review and make recommendations on policy and procedures for Seclusion and Restraint.

III. DEFINITIONS:

None

IV. RESPONSIBILITIES:

A. Chief Executive Officer - Ensures a committee and process exists within the hospital organization to review, monitor and report on seclusion and restraint usage.

B. Licensed nursing staff and Team Leader are responsible for:

1. Reviewing all Seclusion and Restraint Intervention Order/Progress Note and incident report forms for accuracy,

2. Forwarding a copy of the Seclusion and Restraint Intervention Order/Progress Note to the Quality Improvement Director. Forward incident report forms to the safety officer.

C. Director of Quality Improvement is responsible for:

1. Reviewing each Seclusion and Restraint Intervention Order/Progress Note with follow-up as necessary.

2. Ensuring data from these reports are entered into a computer database and aggregated for regular reporting purposes.

D. Medical Director, is responsible for:

1. Ensuring a clinical philosophy which promotes treatment in the least restrictive manner while reducing seclusion and restraint.

2. Reviewing, together with the Seclusion and Restraint Committee, patient medical records and the circumstances surrounding the orders for seclusion or restraint that last 72 continuous hours.

E. Committee Chair - Provides leadership needed to maintain an active, informed and responsive seclusion and restraint committee. The Chair is accountable for the following:

1. Maintain a working Committee.

2. Ensure the Committee conducts itself in accordance with this policy.

3. Assign duties to Committee members as needed to conduct the business of the Committee.

F. Committee Members - Each member of the Committee contributes time and effort to review medical records for incidents of seclusion and restraint. Each member is expected to:

1. Attend and participate in Committee meetings.

2. Be active in Committee education efforts.

3. Support the work of the Committee in specific ways, when so requested.

4. Support the delivery of quality care by providing:

A. Review of seclusion and restraint incidents according to this policy.

B. Seclusion and Restraint Educational Resource: The Committee provides an effective and functioning educational resource, which the Hospital may utilize to assure initial (orientation) and ongoing staff training.

C. Hospital Policy Review: The Committee offers consultation and recommendations for updating and developing seclusion and restraint policy.

V. PROCEDURE:

A. Seclusion and Restraint Report

1. All uses of seclusion and restraint will be reported daily to the Hospital Management Team via the Nursing Shift Report Log.

2. A copy of the Seclusion and Restraint MD Order / Progress Note will be completed and sent to the Director of Quality Improvement at the end of each intervention or, in case of extended interventions, every twenty-four (24) hours.

3. The Director of Quality Improvement will review each Seclusion and Restraint MD Order / Progress Note with follow-up as necessary.

4. Data from these reports will be entered into a computer database. Aggregate data from these reports will be made available to the hospital's administrative and clinical staff on a monthly and as needed basis.

B. Membership:

1. The membership of the Committee will represent clinical staff trained in the use of seclusion and restraint.

2. The chairperson in consultation with the Hospital Administrator and appropriate departmental supervisors will appoint Committee membership comprised of the following:

   a. One psychiatrist;
   b. Two Certified Mental Health Professionals (either full or limited);
   c. One member of the hospital's supervisory staff;
   d. A representative of the Quality Improvement Committee; and
   e. At least one other staff member at large.

3. A psychiatric technician may be recommended by the appropriate bargaining unit (union) and appointed to the committee by the Hospital Administrator.

3. Committee member appointments will be for a one-year period and may be renewed by the chairperson in conjunction with the Hospital Administrator.

4. The chairperson, in consultation with the Hospital Administrator will appoint persons to fill any vacant committee positions that may occur.

5. Additional staff may be asked by the chairperson to consult with this Committee on a case-by-case basis.

C. **Leadership of the Seclusion and Restraint Committee:**

The Administrator of the Hospital shall appoint the Chair.

D. **Meeting Frequency:**

1. The Committee will meet at least twice each month or more frequently at the call of the chair.

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E. **Minutes:**

1. Minutes will be recorded for all committee meetings with copies going to committee membership, the Director of Quality Improvement, Medical Director, Director of Nursing and Chief Executive Officer.

F. **Review of Seclusion, Restraint and Incidents:**

1. The committee will review all reported uses of seclusion and restraint by examining the Seclusion and Restraint Order / Progress Notes filed with the Quality Improvement Director. The Committee will perform a chart review as necessary:

    a. Incidents of seclusion or restraint of 24 hours duration or longer,
    b. Together with the Medical Director, review all incidents of seclusion or restraint of 72 hours duration or longer.

2. In chart reviews, the committee will determine whether:

    a. The intervention used was the least restrictive alternative;
    b. The patient received proper care while in seclusion or restraint,
    c. Proper documentation was entered into the patient's chart; and
    d. The patient was examined by a psychiatrist, licensed nurse, and mental health professional person within the time periods designated in policy.

3. If a pattern of opportunities to improve is noticed, the Committee may request and monitor a plan for improvement.

4. The committee will note whether each incident of seclusion or restraint was implemented appropriately and in accordance with the provisions of

the Hospital's Seclusion and Restraint policy and Treatment and Positional Supports policy.

5. If any use of seclusion or restraint is judged to be inappropriate or out of compliance with policy or statutory requirements, the Committee will:

    a. Immediately do an in-depth review of medical record documentation, and
    b. Recommend a plan of correction to the appropriate supervisory staff and/or Medical Director (when appropriate) so that supervisory staff can take corrective action.

6. The Committee is responsible for tracking these incidents to resolution.

7. Information regarding the use and review of seclusion and restraint interventions will be provided to the hospital's Quality Improvement Committee on a quarterly basis.

G. **Reporting**:

1. The Quality Improvement Director will ensure a process to maintain a database, and prepare and distribute reports regarding these occurrences at periodic intervals but not less than quarterly. This information is analyzed and reported on a quarterly basis to the Management Team, hospital-wide Quality Improvement Committee, and to the medical staff.

2. The Quality Improvement Committee will:

    a. Review aggregate (total hospital and data by treatment unit) seclusion, and restraint data on a quarterly basis, as well as other reports generated by the Seclusion and Restraint Review Committee.
    b. Will identify performance improvement goals for use and reduction of Seclusion and Restraint.

VI. REFERENCES: Related Policies: Seclusion and Restraint; Treatment & Positional Supports; Standards/Statutes: 53-21-146 M.C.A., and C.M.S Standards.

VII. COLLABORATED WITH: Chair, Seclusion and Restraint Review Committee, Medical Director, Director of Quality Improvement, and the Director of Nursing Services

VIII. RESCISSIONS: QI-04, *Seclusion and Restraint Committee* dated February 14, 2000; HOPP# 13-03R. 11191 "Review of Time Out, Behavior Control, Seclusion, and Restraint Interventions" dated November 1991.

IX. DISTRIBUTION: All hospital policy manuals.

X. REVIEW AND REISSUE DATE: November 2007

XI. FOLLOW-UP RESPONSIBILITY: Chairperson, Seclusion and Restraint Committee

XII. ATTACHMENTS: A. Seclusion and Restraint Intervention Order / Progress Note
B. Restraint/Seclusion Review Committee Incident Review Form

_____/___/__		_____/___/__	
Ed Amberg	Date	Thomas Gray, MD	Date
Hospital Administrator		Medical Director	